



COMMENTS to the Centers for Medicare & Medicaid Services, Department of Health and Human Services, CMS-9937-P

RE: HHS Notice of Benefit and Payment Parameters for 2017

Submitted by Community Catalyst

December 21, 2015

Community Catalyst respectfully submits the following comments to the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) in response to the Notice of Benefit and Payment Parameters for 2017, released November 21, 2015.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations, providing leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

We greatly appreciate the opportunity to provide comments to the proposed Benefit and Payment Parameters for 2017. The proposed regulations include many important steps forward for consumers. We applaud CMS for strengthening consumer protections in the proposed regulations, especially in network adequacy standards, qualified health plan certification standards and the attention paid to vulnerable populations. In addition, there are areas the regulations could be further improved to support consumer access to high quality health care. We focus our comments both on the advancements these proposed regulations create for consumers as well as areas where they could still be strengthened.

Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

§ 154.215 Submission of Rate Filing Justification

We applaud CMS’s decision to require that issuers submit a Unified Rate Review Template (Part I of the Rate Filing Justification) for all single risk pool coverage products in the individual, small group or merged markets. We agree that premium increases cannot reasonably be monitored without evaluating the net effect on premiums, including the impact of rate decreases, plans with unchanged rates, and new plans’ rates.

§ 154.301 CMS's Determinations of Effective Rate Review Programs

Public access to information about proposed and final rate increases with a mechanism for public comment is crucial for helping consumers understand rates. While the proposed rule takes important steps to ensure consumer access to proposed and final rate increases, **we recommend adding the following requirements for states to have an effective rate review program:**

- **A sixty-day comment period on all proposed rate increases;**
- **The state's website should prominently display all filing documents so that they are easily accessible, and should include consumer friendly rate summaries.**

Additionally, we urge CMS to make information on final rate increases publicly available prior to the first day of the annual open enrollment period. We recommend that final rate increases should be made available at least 15 days prior to the start of the annual open enrollment period. This will allow consumers and enrollment assisters to become more familiar with the premium rates, which will lead to more informed plan selection.

Part 155 – Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

§ 155.170 Additional Required Benefits

We appreciate that CMS clarifies certain Essential Health Benefits (EHB) requirements, such that in accordance with Section 1252 of the ACA, state standards or requirements around EHB must be provided uniformly outside and inside the Exchange for the individual or small group markets. We would like CMS to require state regulatory enforcement on EHB base-benchmark plans and subsequent QHPs to ensure that states do not end up with imbalanced markets. We support that the proposed rule designates the state rather than the Exchange as the entity in charge of monitoring and designating EHB.

We urge transparent, continuous, and meaningful oversight of EHB base-benchmark plans and subsequent plan benefit packages that will take effect at the beginning of 2017. We also urge CMS to provide a clear and publicly available timeline of how CMS and states should enforce and monitor EHB. We believe CMS can accomplish this by:

- Considering the comments and concerns from the EHB base-benchmark plan process as well as subsequent QHPs, particularly from advocates and stakeholders who are in touch with EHB gaps for enrollees;
- **Spot checking state-approved QHPs for compliance with federal requirements**, such as Section 1557 and the 2008 Mental Health Parity and Addiction Equity Act. CMS should determine whether these plans violate the ACA by mirroring gaps in EHB benchmarks, or through other coverage design issues, and enforce compliance.

We strongly recommend CMS to clarify the process of how states decide what is in “excess” of EHB. We seek more guidance on what constitutes enactment that is directly attributable to state compliance with Federal requirements. We think that giving more examples

and explicit guidance will empower states to know that they have the flexibility to enact certain mandates or clarify ones enacted before December 31, 2011 without cost.

At §155.170(a)(3) of the proposed rule, CMS proposes designating the state as the entity that identifies which state-required benefits are in excess of EHB. While we agree that state regulators may be more familiar with EHB and should in general exercise authority to monitor and enforce compliance, **we ask that CMS conduct regular QHP spot-checks to ensure that the rule is uniformly applied across states and not being used to discourage enrollment of individuals with high medical needs.**

We recommend that CMS establish a process to enable additional state-required benefits in excess of EHB that would be no cost to the state if they fill in critical coverage gaps. We recognize that this would entail careful cost calculations to ensure that additional mandated benefits do not get passed on as cost-sharing to consumers. Nevertheless, we are concerned that QHP benefit packages do not meet the needs of vulnerable populations and that benefit packages still maintain harmful gaps in coverage. For instance, CMS’s recent comparability study shows that CHIP plans in all states are much more affordable and comprehensive for “child-specific” services than plans on the Exchange.¹ If children on CHIP ever have to transition to the Exchange, we are concerned they will lose crucial coverage and cost-sharing protections – begging a discussion of how to make QHP benefit packages both affordable and high value for consumers. In addition, CMS should provide further guidance to states regarding the types of benefit mandates that a state may enact to comply with federal requirements that will not lead to additional costs.

We urge CMS to take measures to ensure that QHP issuer cost calculations regarding the cost attributable to each additional state-required benefit are accurate (§ 155.170(c)(2)(iii)). We also recommend that CMS release this data for public stakeholders (consumers, policymakers, researchers, etc.) to better understand the relationship between benefits and the affordability/cost of plans.

§ 155.210 Navigator Program Standards

Overall, we support the proposed changes to § 155.210 that would require Navigators to provide targeted assistance to serve underserved and/or vulnerable populations within an Exchange service area. We feel that Navigators are uniquely positioned to serve these populations because they are currently required to have expertise in the needs of these populations, and many are from community and consumer-focused nonprofits who have strong ties to and pre-existing relationships with these communities. As a result, we feel that Navigators are duly qualified to meet this requirement.

Regarding § 155.210(e)(8), **we request that CMS further explain how Navigators are expected to “target” or “focus” their work on these populations, since they are also required to assist any consumer seeking assistance.** In particular, we ask that CMS further

¹ Certification of Comparability of Pediatric Coverage Offered by Qualified Health Plans, CMS, November 25, 2015, available at: <https://www.medicaid.gov/chip/downloads/certification-of-comparability-of-pediatric-coverage-offered-by-qualified-health-plans.pdf>

define what activities or strategies they view as “targeting” a particular population. In addition, if the Exchange only defines one population, we ask that CMS provide guidance on how Navigators can or should assist other underserved or vulnerable populations as well as all other consumers seeking assistance. Since Navigators often have experience and insights based on their work in the communities they serve, **we believe that the Exchange should take in Navigators’ input before making a final decision.**

We also support CMS’s decision to require Navigators to help consumers with post-enrollment assistance in § 155.210(e)(9) because we firmly believe that robust and comprehensive enrollment assistance does not stop at enrollment. Our experience with assisters on the ground has taught us that helping consumers gain and maintain effective health coverage requires assisting with post-enrollment needs in addition to the application and plan selection process. Assisters are uniquely positioned to provide post-enrollment assistance because they are often the first point of contact for consumers who have post-enrollment questions, such as how to access care, find a provider, or file an appeal. Therefore, we greatly support requiring Navigators to provide information on these post-enrollment areas to help ensure consumers are fully informed of their post-enrollment rights and responsibilities.

However, we are concerned that the proposed regulations in § 155.210(e)(9)(i)-(iv) as written do not provide enough guidance to Navigators about the type or amount of assistance they are expected to provide. We agree with CMS that requiring Navigators to provide information to consumers on post-enrollment is an effective way to ensure consumers are educated about these areas, but we also feel that Navigators should not be expected nor held out as the experts in these areas. Moreover, since other community resources are available to provide assistance with these consumers, and particularly because some of these community resources are trained experts (i.e., legal service organizations and tax preparers), we believe Navigators should be required to be aware of these other community resources and know when and how to provide referrals so that consumers can be made aware of these resources and make an informed decision regarding from whom they would like to receive assistance from. **Therefore we recommend that under § 155.210(e)(9), CMS should replace “assistance with” with “education about consumer rights and responsibilities, and appropriate referrals to community resources” so that the role of Navigators can be more clearly defined and delineated to the services Navigators already have expertise in.**

Regarding § 155.210(e)(9)(i), we propose that Navigators’ duty with respect to eligibility appeals be limited to making consumers aware of their right to appeal, providing basic education on the appeals process, and making appropriate referrals for legal assistance when possible. As written, we think that requiring Navigators to provide “information and assistance with the process of filing Exchange eligibility appeals” puts Navigators at risk of conflating their role as Navigator with that of an authorized (legal) representative. This conflation of roles could lead Navigators to act beyond their permissible scope of assistance by advocating for the consumer and would put consumers at risk of not receiving adequate legal advocacy. We think the rule should clearly define the type of assistance Navigators provide with respect to eligibility appeals to help both Navigators and consumers recognize where a Navigator’s assistance stops and legal assistance becomes appropriate or necessary. **Therefore, we recommend changing the language of § 155.210(e)(9)(i) to: “Understanding the right to appeal an adverse Exchange eligibility**

determination, the basic process of Exchange eligibility appeals, the availability of Exchange resources on this process, and referrals to legal assistance where available.”

Regarding § 155.210(e)(9)(ii), and similar to the recommendation above, we propose that Navigators’ duty with respect to exemptions be limited to educating consumers about the availability of exemptions and helping consumers understand the process of applying for exemptions obtained through the tax filing process. To help Navigators meet this new requirement, **we recommend that CMS provide Navigators with additional training or information from IRS on the process of applying for exemptions through the tax filing process so they can effectively help consumers.** We also support the requirement that Navigators should inform consumers that they cannot provide tax assistance or advice and provide an appropriate disclaimer regarding the limitation of their services prior to providing assistance. However, we feel that providing consumers with an oral disclaimer that they are not tax advisers and cannot provide tax advice prior to providing any other type of assistance is not the best way to initiate or maintain a strong relationship with a consumer and may cause consumer confusion. Rather, **we suggest that Navigators include disclaimer language within the consent form provided to consumers that authorizes Navigators to provide enrollment assistance and gain access to consumers’ personally identifiable information (PII).** We believe that including the disclaimer language in the authorization form will allow consumers to be fully informed of the scope of Navigator duties while also allowing Navigators to begin enrollment appointments in their traditional manner and effectively build and maintain relationships with consumers during the appointments.

Regarding § 155.210(e)(9)(iii), we support requiring Navigators to assist with the tax credit reconciliation process and agree with CMS that Navigators have expertise related to Exchange eligibility and enrollment rules that uniquely qualify them to help consumers in this area. However, we are also aware of the resource limitations that Navigators and their funding agencies may face and are concerned about the amount of time that may be required for Navigators to familiarize themselves with all of the IRS resources available, as well as all of the tax law, legal aid, and Volunteer Income Tax Assistance (VITA) agencies that may be available in their area. To better help Navigators meet this new requirement, **we recommend that CMS incorporate new modules about tax credit reconciliation and referrals to tax preparation services into the annual assister training.** Both new and returning Navigators should be required to complete the modules during this pre-dedicated, mandatory time to build the level of knowledge needed to assist consumers. Similarly, with respect to the proposed language at 45 CFR 155.210(e)(9)(v), **we request that CMS provide Navigators with additional training or information from IRS on the availability of VITA or Tax Counseling for the Elderly Programs so that they can know where and how to make appropriate referrals.**

We strongly applaud CMS for codifying assistance with health insurance literacy needs as a formal requirement for Navigators in § 155.210(e)(9)(iii). Our experience on the ground has taught us that consumers often return to assisters with questions regarding how to use their coverage to access to care, and formalizing this type of post-enrollment assistance will ensure consumers are able to use and maintain meaningful coverage. We appreciate that CMS offered the *From Coverage to Care* series as an example, but **we further request that CMS provide access to additional resources and information Navigators can use to help increase their**

ability to assist with health insurance literacy. Before creating additional health insurance literacy requirements for Navigators to provide assistance in, CMS should provide additional information or referrals to resources of where assisters can become knowledgeable of health insurance literacy topics. In particular, many of the assisters we work with report that they often contact issuers to obtain information of specific plan benefits, terminology or services. Therefore, **we recommend that CMS require issuers or agents/brokers to provide information to assisters regarding plan benefits and details to increase Navigators' ability to assist with health insurance literacy.**

We request that CMS update and republish current regulations and guidance to make clear whether and how Navigators are permitted to collect, disclose, access, maintain, store and/or use PII to carry out these proposed post-enrollment activities. We understand that CMS recently updated the model Navigator consent forms to allow consumers to authorize Navigators to use PII to follow up with consumers for certain post-enrollment needs. However, our experience working with assisters has informed us that many Navigators still feel hesitant to maintain any PII after an enrollment appointment other than the authorization form, and many do not keep any PII after an enrollment appointment. Using PII will be a critical component to being able to follow up with consumers and carry out these post-enrollment activities.² **Therefore, we request that CMS republish the current guidance so that more Navigators can become aware of it, as well as update the current guidance to make explicit that Navigators can keep and use PII to engage in post-enrollment assistance.**

Lastly, **we strongly urge CMS to invest funding in Consumer Assistance Programs (CAPs) to assist Navigators in meeting these new requirements.**³ Because CAPs have been assisting consumers with health insurance literacy and filing appeals for years, CMS should re-engage with these entities and provide funding to them. We feel that supporting CAPs and fostering a relationship between Navigators and CAPs will best ensure that Navigators can meet these new health insurance literacy requirements.

§ 155.220 Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs

We applaud CMS for proposing to streamline the application process for consumers who enroll with the assistance of agents and brokers. We are concerned, however, that the proposal to allow brokers to conduct end-to-end enrollment through an Exchange-approved web service will negatively impact consumers.

As specified in § 155.220(c)(1), agents or brokers that currently conduct direct enrollment through a web-broker must direct consumers to the Exchange website to complete their applications and receive their eligibility determination. Even with this current system, many consumers who enroll with agents or brokers are enrolling in coverage without making an account on the Exchange website. Many consumers are unaware that they have an application with the Exchange and that they can create and link an account to that application. This prevents

² 45 CFR 155.210(e)(9)

³ 45 CFR 155.205

these consumers from reporting life changes on their applications and from returning to the Exchange for the renewal process online.

Therefore, while the end-to-end streamlining of the application may improve the consumer experience while they are working with an agent or broker, more consumers will not be informed of how to access their applications online. **We recommend that, if agents and brokers are able to conduct end-to-end enrollment, that they be required to instruct consumers as to how to create an account on the Exchange website, how to link that account to their new application, and how to access the application online.**

§ 155.225 Standards Applicable to Certified Application Counselors (CACs)

Overall, we support requiring CACs to report the same information metrics as Navigators. We believe this requirement will help provide a more comprehensive view of how enrollment assisters are contributing to enrollment efforts. However, **we request that CMS change the language of the required reporting data to better capture the full extent of enrollment assistance that CACs provide.** For example, since “application and enrollment assistance” can signify different types of activities, from answering a consumer’s question to helping them complete an application or selecting a plan, we request that CMS instead collect information on: the number of consumers a CAC assisted during appointments, (i.e., sometimes CACs assist multiple consumers during a single appointment), as well as the outcome of those appointments. Collecting data in this way will better capture a more complete view of how CACs assist consumers with their application and enrollment needs in ways that perhaps did not result in a completed application or plan selection – i.e. many consumers enroll on their own after receiving assistance from a CAC. Additionally, because assisters are required to provide their ID number on the applications they assist with submitting, requesting information on the number of individuals who applied for and enrolled in a QHP is duplicative.

§ 155.320 Verification Process Related to Eligibility for Insurance Affordability Programs

Overall, **we support allowing Exchanges to establish their own reasonable threshold at which it must follow the alternative verifications specified in § 155.320(c)(3)(vi).** Our network of enrollment assisters has reported to us over the last two years that for many consumers, accurately projecting annual household income can be difficult due to seasonal employment or fluctuating income. We appreciate CMS allowing Exchanges to set a reasonable standard that can be greater than the current standard of 10% and accounts for a realistic variation of consumers’ projected annual income.

Additionally, **we applaud CMS for considering ways to notify current Exchange enrollees about their upcoming or current eligibility for Medicare.** Our network of enrollment assisters have attested to working with consumers who are having difficulty transitioning from Exchange to Medicare coverage due to being unaware of dual eligibility or dual enrollment. We support including pop-up messages on HealthCare.gov to inform consumers turning 65 within the benefit year of their Medicare eligibility. We also recommend that CMS provide Exchange notices, such as the open enrollment notice or eligibility redetermination notice that inform Medicare-eligible consumers of their eligibility and of the Medicare open enrollment dates. Lastly, the

HealthCare.gov application question that asks consumers to allow the Exchange to access 5 years of income and other verification data could provide an option to consumers turning 65 to provide access to only the number of years before the consumer turns 65, and provide a pop-up message explaining why.

§ 155.335 Annual Eligibility Redetermination

We applaud CMS for considering ways to minimize potential disruptions of enrollee eligibility by providing continuous enrollment in silver-level plans with cost-sharing reductions if that plan is no longer available for reenrollment, and if the enrollee's current product no longer includes a silver-level plan. **We support reenrolling consumers in a silver-level plan offered by the same issuer in a product that is most similar to the consumer's previous product.** We agree with CMS that transitioning enrollees in this manner is an efficient way to reenroll consumers that also supports their health needs and financial situations.

We further applaud CMS for considering alternative re-enrollment hierarchies with a focus on what might be most important to consumers. **However, while we know that low-premium plans are important to many consumers, we are concerned that defaulting to the lowest cost plan will have negative consequences on network adequacy and market competition.** Because the lowest cost plans often correspond with the narrowest networks on the Exchange, we are concerned that consumers will opt into this re-enrollment option enticed by the premium implications, and end up with a plan that has an inadequate network of providers that will not address their needs, or with cost-sharing that substantially increases their out-of-pocket costs.

Based on our experience in Massachusetts, we recommend that consumers who opt into a default enrollment should be assigned to at least the three lowest cost plans in the service area to increase competition. The 2006 Massachusetts health reform law set up the Commonwealth Care program subsidized health insurance program. The program was managed by the state's exchange, called the Health Connector. The Connector accepted bids from five managed care companies to provide coverage to members of the program. Members below 150% of poverty had no premium, while those above that level had sliding scale premiums.

Initially, Massachusetts's auto-enrolled non-premium paying members who did not select a managed care plan into the lowest-cost plan for their region. The Connector hoped that the reward of getting auto-enrolled members would spur plans to bid as low as possible. They also hoped it would save the Connector money.

By the second or third year, the Connector saw that plans that had no reasonable likelihood of being the lowest-cost plan had no incentive to try to submit an aggressive bid so the Connector altered their auto-assignment methodology. Initially, the lowest bidding plan would get 75% of the auto-renewed members, and the second lowest would get the remaining 25%. In later years they altered this further to give some auto-assigned members to the third- and even fourth-lowest plan.

Therefore, we recommend that if lowest cost is the primary factor in determining which plan to automatically enroll consumers in, then consumers who opt into automatic enrollment should be assigned to at least the three lowest cost plans in the service area to increase competition.

Additionally, we recommend that other factors be considered when determining a

reenrollment hierarchy so that consumers can better maintain continuity of care, such as plans with similar provider networks and drug formularies. For example, machine readable data could be used to identify plans with the most similar provider networks and drug formularies to the consumer's current plan.

§ 155.400 Enrollment of Qualified individuals into QHPs

Rules for First Month's Premium Payments for Individuals Enrolling with Regular, Special, and Retroactive Coverage Effective Dates.

We support the proposal to allow issuers to establish reasonable policies regarding premium collection, and further allow them to collect an amount less than the full amount without triggering a grace period or the consequences of non-payment. We believe that allowing for this flexibility will provide for better continuity of coverage and care that will benefit consumers in addition to issuers. We strongly support policies that avoid situations in which consumers who owe only a de minimis premium amount have their coverage terminated due to nonpayment. We believe the proposed regulation will allow for consumers, and particularly low-income populations, to avoid coverage terminations and maintain access to care.

§ 155.410 Annual Open Enrollment Period

In general, we support the justifications for continuing November 1 as the first date of the 2017 annual open enrollment period. We agree that keeping the 2016 dates would likely reduce consumer confusion regarding effective dates of coverage. However, **we recommend providing a later end date than January 31, 2017 that extends into the tax season.** We recommend that CMS alter the dates of the annual open enrollment period in this way so that it aligns with the Medicare open enrollment period, most employer-sponsored insurance offerings, as well as part of the 2017 federal income tax return season.

Additionally, extending the open enrollment period through some of the tax return filing season would allow uninsured consumers to enroll in coverage after they have paid the penalty for being uninsured the prior year. While the "tax-season SEP" has been offered in previous years to consumers who first became aware of the penalty when filing their tax returns, an open enrollment deadline in tax-filing season would be more publicized and well-known to consumers, and is therefore more likely to result in increased enrollments. In addition, extending open enrollment through the tax season would provide consumers with more time to review their Exchange coverage options thoroughly, and would also give consumers more opportunities to obtain enrollment assistance.

Lastly, a longer open enrollment period would provide enrollment assisters more time to advertise their services and conduct outreach. We recognize that extending the deadline for any date after February 15 would cause consumers to still pay some of the penalty for being uninsured for more than 3 months in 2017. However, we feel that it is nevertheless important to provide for extended opportunities for enrollment through some part of the tax season so that consumers can obtain coverage and access needed care.

§ 155.430 Termination of Coverage

We support the addition of § 155.430(b)(1)(iv) allowing enrollees to retroactively cancel or terminate enrollment in a QHP in situations where the enrollment or continued enrollment was a result of error, misconduct or fraud committed by an entity other than the enrollee, or if the enrollment was unintentional, inadvertent or erroneous and was the result of error or misconduct of an officer, employee or agent of the Exchange or CMS, or a non-Exchange entity providing enrollment assistance. Our network of enrollment assisters have attested to enrollments happening under these circumstances and the detrimental financial effects they have had on consumers. Therefore, we support the inclusion of these justifications for cancellation or termination as they protect consumers from unfair financial harm and promote fairness within the Exchanges.

§ 155.605 Eligibility Standards for Exemptions

We support the proposed changes to § 155.605, in particular the amendments removing the requirement for consumers to obtain an eligibility determination from the consumer's state Medicaid office prior to becoming eligible for the "Medicaid gap" exemption. We agree with CMS that removing this requirement would alleviate a significant burden on consumers as well as reduce state administrative costs. We further support providing this exemption for a calendar year to any individual determined ineligible for Medicaid solely as a result of the state not expanding its Medicaid program. We also support allowing individuals to claim this exemption on their tax return rather than applying through the Exchange. Our network of enrollment assisters and their experiences support the view that both proposed changes would significantly alleviate burdens on consumers and streamline the exemption application process. **Furthermore, we strongly urge CMS to consider providing an exemption from the individual shared responsibility provision for consumers who are erroneously determined ineligible for APTCs by the Exchange and do not to enroll in coverage as a result.** Similar to the proposed changes under § 155.430, we believe that creating an exemption for these individuals would protect consumers from unfair financial harm as well as promote overall fairness within the Exchange.

§ 155.1000 Certification Standards for QHPs

We applaud CMS for proposing to allow FFEs to exercise greater active purchasing authority in plan certification in order to provide consumers with high value, high quality plan options. We believe that the objective of the Exchange is to create a market that consumers can trust as a source of value, and active purchasing supports this goal. We agree that CMS should allow FFEs to deny QHPs certification that meet minimum standards, but are not ultimately in the interest of consumers.

We recommend that CMS evaluate a number of factors in addition to the minimum certification requirements. CMS should include, but not limit to, denying certification to plans that have increased levels of consumer complaints or a track record of standards violations. For example, CMS should consider denial of certification for plans that have a recent history of repeated or egregious violations of:

- Nondiscrimination standards (such as by placing all HIV medications on a highest tier with high cost-sharing);
- Network adequacy requirements;
- Protocols related to consumer complaints and appeals;
- Affordability protections; and
- Coverage and provision of Essential Health Benefits.

Denial of certification for plans that have a poor track record in any of the above areas will create a strong incentive for plans to comply with standards over time. This will make the Exchange a trusted source of quality coverage for consumers. In addition, **we recommend that CMS create a transparent process that considers input from a multitude of stakeholders, including consumer advocates and consumers, when identifying the standards on which plans will be selected.** Input from stakeholders will be crucial to understanding QHP performance and past consumer experience. In addition, we want to see a process for gathering consumer input to capture differences in attitudes based on income, race, and health status.

We recommend that assessing QHP standards should include, but not be limited to, data captured from the Quality Initiatives from the Quality Rating Strategy and quality improvement strategy (QIS). We reiterate our comments made in both letters we submitted to CMS regarding Exchanges and Qualified Health Plans, Qualified Rating System, Framework Measures and Methodology⁴ and the 2016 Notice of Benefit and Payment Parameters.⁵ Particularly we recommend that quality standards should focus on measures that matter most to patients and are presented to consumers in a way that is meaningful. Measures should also focus on outcomes and on reducing health disparities.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

§ 156.20 Standardized Option Definition

Overall, we are very supportive of a standardized plan option and appreciate that CMS is thinking about how to lessen consumers' burden when it comes to plan choice. However, **we urge CMS to make standardized plans a requirement for issuers offering a QHP in an FFE in 2017.** We fear that making standardized plans optional will not result in enough participation by the issuers to make the standardized option meaningful. Other states cited in the regulation as examples for the standardized option, like California, Massachusetts, and New York, require issuers to have at least one standardized option on the exchange (and all plans in California are standardized). At the very least, if CMS does not make standardized plans a requirement, we

⁴ Community Catalyst. (January 21 2014). Comments to the Department of Health and Human Services, Centers for Medicare and Medicaid Services. CMS-3288-NC. Re: Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS), Framework Measures and Methodology http://www.communitycatalyst.org/resources/comment-letters/document/CC_Quality_framework_Exchange_comments_FINAL.pdf

⁵ Community Catalyst. (December 22, 2014). Comments to the Department of Health and Human Services and Centers for Medicare and Medicaid Services. Re: HHS Notice of Benefit and Payment Parameters for 2016. <http://www.communitycatalyst.org/resources/comment-letters/document/NBPP-CC-comments-122214-FINAL.pdf>

believe the incentive to offer a standardized plan must be strong. **We recommend that CMS make all of the standardized plans appear at the top of the Exchange website and delineate these plans from non-standardized plans in a way that encourages consumers to consider these standardized options.**

As proposed, the specialty drug tier for the standard silver plan has a 40% coinsurance responsibility for the enrollee. For individuals with chronic conditions who rely on costly medications for their treatment, a coinsurance of 40% would likely result in consumers rationing medication or forgoing it all together. Requiring a copay would increase transparency and better allow a consumer to understand their potential financial liability in a standard plan. Therefore, **we urge CMS to adopt a copay, instead of coinsurance, for specialty drugs in standardized plans.** A 2015 study on discriminatory benefit design defined adverse tiering – when issuers placed all drugs used to treat HIV on the highest cost-sharing tiers – using a cutoff of 30% coinsurance, which translated into an additional \$3,000 annually for HIV positive beneficiaries.⁶ Therefore, to minimize the potential for medications to become cost prohibitive for individuals with chronic illnesses, and in the event that CMS decides to keep a coinsurance, **we recommend that CMS lower the coinsurance to at least 20%.**

Additionally, CMS should define “specialty tier” so that issuers do not put all expensive drugs in specialty tiers. The specialty tier was initially designed as a way to designate those drugs that required additional assistance (often from pharmacists) with the drug’s administration. Even so, plans have increasingly assigned this tier to many different drugs, seemingly to discourage usage, or to pass more costs onto consumers. CMS should clarify drug tier terminology so that “specialty tiers” can only be used for “specialty” medications.

As proposed the standard plans do not offer a benefit design that is standardized across all EHB services. **We urge CMS to add all EHB services to the standard benefit design.** The major categories that are not specified include durable medical equipment, emergency transport, mental/behavioral health inpatient services, substance use disorder inpatient services, habilitative services, maternity care, and children’s dental and vision services. It is misleading for shoppers to label a plan “standardized,” yet to simultaneously have numerous non-standardized elements in each plan. Consumers will be expecting that all aspects of a standard plan to be standardized, which could potentially expose consumers to large out-of-pocket costs in the future. Without accounting for all EHB services, consumers who are trying to compare plans for a service such as maternity care, which is currently not in the standard benefit design, will be unable to use the standard plans to help narrow their options. Additionally, failing to standardize all benefits could allow issuers to set cost-sharing amounts that discourage enrollment by those with certain chronic diseases, particularly because the services not currently standardized will likely be disproportionately used by those with certain health conditions.

We applaud CMS for making certain services exempt from the deductible in the proposed standardized benefits. However, **we urge CMS to include outpatient rehabilitative services and laboratory services as exempt from the deductible** as these are commonly used services that are exempt from the deductible in many of the states who have implemented a standardized

⁶ Jacobs, Douglas and Benjamin Sommers. “Using Drugs to Discriminate—Adverse Selection in the Marketplace.” *N Engl J Med* 2015; 372:399-402. January 29, 2015.

option. We appreciate that CMS has to balance the overall cost of a standard plan with the number of services that a consumer can access without meeting a deductible.

Finally, because we believe that the best policy is for CMS to eventually limit plans to only the standard options, **we urge CMS to limit the number of non-standardized plans in addition to continuing to apply the meaningful difference standard.** Also, to ensure that the standardized plans remain competitive, we recommend that CMS use its new authority to deny QHP certification, as described in §155.1000, if non-standard plans offered on the Exchange offer an enticing price to a consumer but otherwise are not in the consumer's best interest due to extremely narrow networks, discriminatory benefit design, etc. Consumers focused on price often choose against their own interests; for example, selecting a lower premium plan that results in higher total spending when cost-sharing is factored in. Consumers will be best served if the variety of plans reflects the choices they do care about – providers and treatments – as opposed to an endless number of ways to reconfigure affordability.

§ 156.122 Prescription Drug Benefits

We urge CMS to not allow changes to the exceptions process for prescription drugs. CMS revised the exceptions process for prescription drugs specifically to establish a more uniform process across plans and issuers. States will begin adopting the new exceptions rules in 2016, yet would be allowed to use a different process in 2017. **We recommend that CMS require states to comply with the EHB exceptions process, which includes an expedited exceptions process, a standard exceptions process, and a secondary external review.** Yet, if CMS decides to move forward with allowing state flexibility in determining the exceptions process, then CMS should set some minimum standards and create a tool for states to use in determining whether their appeal laws and regulations are comparable to the EHB exceptions standard.

We applaud CMS for recognizing the importance of medication assisted treatment for substance use disorders, particularly opioid addiction. We strongly believe that it is necessary to ensure access to medication-assisted treatment (MAT) for opioid addictions under the substance use disorder Essential Health Benefit. Access to MAT where medically indicated is a critical and necessary component of health coverage within the mental health and substance use disorders EHB category. However, we caution that the use of prescription drugs to treat substance use disorders is only one component of a comprehensive treatment plan that generally also includes counseling and other therapies.⁷ Medication coverage alone will continue to fall short of addressing the health needs of this population if the overall benefit package for mental health and substance use disorders is not sufficiently comprehensive.

The widespread exclusion of medications used to treat substance use disorders in QHPs is one of many reasons that many QHPs fail to meaningfully comply with the EHB standard. Based on a review of the 2017 state benchmark plan drug formularies, private insurance plans governed by the ACA cover significant numbers of medications to help in the treatment of other chronic illnesses including hypertension, cancer and heart disease. The same review suggested significantly more limited coverage of substance use disorder medications than medications

⁷ Medication Assisted Treatment for Substance Use Disorders Bulletin, July 11, 2014, available at: <http://www.medicaid.gov/federal-policy-guidance/downloads/cib-07-11-2014.pdf>

utilized in the treatment of other chronic illnesses. Failure to provide coverage of substance use disorders medications in a comparably comprehensive way to coverage of medications for other chronic diseases suggests a violation of the federal parity law. **We urge CMS to include in the final rule clarifying language that, to comply with the EHB and parity requirements of the ACA, plans must cover all FDA-approved addiction medication.**

§ 156.230 Network Adequacy Standards

We applaud CMS for recognizing the need to strengthen network adequacy standards and for proposing a number of new protections that would apply for the 2017 plan year. Even though the National Association of Insurance Commissioners has now completed its work on its updated Health Benefit Plan Network Access and Adequacy Model Act (Model Act), it is not yet clear how many states will adopt it in whole or in part. Therefore, **we strongly encourage CMS to move forward with strong network adequacy standards that can serve as a floor of protection for consumers enrolled in QHPs beginning in 2017.**

State Selection of Minimum Network Adequacy Standards:

We strongly support requiring an affirmative review of QHPs in FFE states, using a set of minimum quantitative time and distance and provider-enrollee standards. We are encouraged to see that FFE states that do not review for network adequacy or set minimum quantitative standards are subject to an independent review under a federal default time and distance standard. We are looking forward to reviewing the specific criteria detailed in CMS's 2017 Letter to Issuers. This is a critical step to ensure consumers have access to all covered services without unreasonable delay. However, **we believe that the final rule should be revised to require all states—SBE and FFE states—to conduct network adequacy reviews of QHPs using a minimum set of quantitative standards.** A number of states with SBEs do not currently use quantitative standards for evaluating network sufficiency.

We believe that the Medicare Advantage standards, with their five geographic categories that account for geographic variations in provider accessibility and population distribution, would serve as an appropriate basis for QHP federal default standards. Nonetheless, **we recommend that CMS incorporate minimum provider/facility ratios in its standards for QHPs.** In addition, we recommend that CMS supplement the Medicare Advantage standards to account for differences between Medicare plans and QHPs in their covered population and covered services. In particular, **we suggest CMS incorporate the use of pediatric-specific standards** that would allow for an assessment of provider networks that is based on the inclusion of in-network pediatric providers capable of providing appropriate care from well-baby care to care for children and youth with special health care needs, including those with serious, chronic or complex conditions.

Regardless of what quantitative standards are used, **we urge CMS to implement greater scrutiny on the inclusion of specific provider types, particularly hospital-based physicians at participating hospitals.** This is a critical step to protect consumers from balance billing.

In addition to time and distance standards and provider-enrollee ratios, **we recommend that CMS set maximum appointment wait times** for a wide range of services including primary care, specialty care, urgent care for medical and dental services, urgent care for mental illness and substance use disorders, non-urgent mental and behavioral health services, life-threatening emergency care, and expanded practice access (including same day appointments for urgent needs and after-hours access to clinician advice).

When determining network adequacy for QHPs that use a tiered network, we urge CMS to clarify that only providers in the lowest cost-sharing tier will be counted for purposes of determining network adequacy. Using providers who are assigned to a higher cost-sharing tier can result in significantly more out-of-pocket costs. Given the significant cost impact, consumers should be able to access all covered benefits through providers in the lowest cost-sharing tier without unreasonable travel or delay.

Proposed Rules to Ensure Continuity Of Care

We commend CMS for recognizing the need for consumer notification and a transition period when one of their providers is being discontinued from their plan's network. Specifically, CMS proposes requiring QHP issuers in all FFEs to notify enrollees about a discontinuation of an in-network provider and ensuring that enrollees have continuity of care protections when a provider is terminated without cause. In general, we support these important consumer protections but believe they are important enough to warrant applying them to all QHPs, not just those in FFE states.

With respect to the new notification requirements, it is important that consumers know that their provider will no longer be part of their network and that they know of their rights to continuing care if in the midst of an active course of treatment. **We recommend that CMS clearly define “regular basis” as being seen by the provider at least once within the preceding year, rather than leaving this up to issuers’ discretion. We also recommend that all patients being seen by a primary care professional be notified when that provider is no longer in the network,** as is required under the NAIC’s Model Act and for Medicare Advantage plans. Consumers who are generally healthy may not need to see their primary care provider once a year, but they still need to know when their primary care professional is leaving their network. Finally, **CMS should require that these notices to patients include information about enrollees’ right to receive transitional care from their provider if they are in the midst of an active course of treatment.**

We are pleased to see proposed requirements that ensure continuity of care. Allowing enrollees in active treatment to continue until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates in cases where their provider is terminated is an important step to minimize disruptions in care and access to medically necessary services. However, **we believe that the 90-day transition period should be the minimum, rather than the maximum, length of time for patients being treated for a life-threatening condition, a serious acute condition, pregnancy, or another health condition (such as severe depression or a mental health condition) that would be worsened by discontinuing care by the treating health care provider.** More specifically, we support allowing care for women in their second or

third trimester of pregnancy to be extended through the post-partum period, commonly defined as the six weeks after birth, even though this may be longer than 90 days.

We also recommend that patients who have been diagnosed with a terminal illness, defined as a disease or condition that cannot be cured or adequately treated and that is reasonably expected to result in the death of the patient within six months, be allowed to continue with their provider until the end-of-life, even though this may extend beyond 90 days. We also support providing a continuity of care transition period for new QHP enrollees, as CMS has previously encouraged QHP issuers to permit. Specifically, new enrollees in the midst of an active course of treatment should be able to continue that treatment with their current providers for up to 90 days, even if those providers are not in their new plan's network.

Proposed Rules To Limit Out Of Network Cost Sharing

We appreciate that CMS acknowledges the problems faced by consumers when they receive covered services by an out-of-network provider at an in-network facility, often without their knowledge or control. **However, the remedy proposed does very little to address the financial harm that consumers experience in these situations.**

First, by specifically referring to “cost sharing,” our reading of the proposed regulation is that balance billing amounts would not be required to count toward enrollees’ annual limitation on cost sharing. As defined in 45 CFR §155.20, cost sharing does not include balance billing amounts for out-of-network providers. Moreover, the regulatory definition of cost sharing also specifically excludes spending for non-covered services, which would not benefit consumers enrolled in plans with no out-of-network coverage. Therefore, **we strongly urge CMS to allow the amounts paid by an enrollee, including balance billed amounts, for an essential health benefit provided by an out-of-network provider at an in-network setting to count towards the enrollee’s annual limitation on cost sharing, even if the QHP does not otherwise include an out-of-network benefit.**

Second, the very limited protection proposed is rendered even more futile by allowing issuers to avoid counting any costs resulting from care provided by out-of-network providers in in-network facilities toward the maximum out of pocket limit if they simply provide a written notice to the enrollee 10 business days before the provision of care. Notice alone is not sufficient to protect consumers from unfair charges that often result when consumers have very little ability to control the providers that care for them. In addition, **while we do not object to a written notice as long as it is not used as an alternative to providing real financial protection to consumers, the required notice should give consumers meaningful information about the ramifications of being seen by out-of-network providers.**

Finally, we note that this new provision does nothing to protect consumers from balance-billed amounts that are provided at out-of-network facilities. While issuers are required to charge in-network cost-sharing rates for emergency services provided at out-of-network facilities, consumers can still be subject to balance bills. Again, given that consumers in an emergency often do not have any control over the facility they are taken to or the providers who treat them **we strongly urge CMS to adopt stronger requirements to protect enrollees from**

unexpected balance billing by out of network providers. We strongly believe that enrollees should not be subject to out-of-network cost sharing in cases when they could not be reasonably expected to know or control whether care is being delivered by out of network providers. These situations include but are not limited to: (1) unavailability of in-network providers for a covered EHB; (2) unexpected utilization of out-of-network care for a covered EHB; (3) emergency care; (4) out-of-network care as a result of an inaccurate provider directory.

Network Rating

We are pleased to see CMS’s proposal to provide a rating of each QHP’s relative network breadth on HealthCare.gov, and we strongly urge CMS to move forward with implementing this system. Currently, consumers have no way of knowing what the relative breadth of their plan’s network is. Particularly with the growth of plans with narrow networks and no out-of-network coverage, it is critically important that consumers understand the network that comes with the plan they are choosing and the trade-offs that come with that choice. We strongly support CMS in developing standard definitions for measuring the breadth of provider networks, along with a clear, concise rating system for communicating the breadth of the networks to consumers. Such a system will enable consumers to make better, more accurate comparisons of the QHPs available to them.

With respect to the methodology, we encourage CMS to factor in both physicians (primary care and specialty physicians) and hospitals when evaluating and rating health plan networks. We believe it would be useful to provide separate ratings for breadth of network by categories of providers: primary care professionals, specialty physicians, hospitals, pharmacies, and other facilities. Those ratings could then be rolled up into a single overall rating of network breadth. In this way, networks with a large number of physicians, but few hospitals; or with a large number of primary care professionals, but few specialty physicians could be more accurately analyzed and categorized. Such a system would also allow consumers to obtain rating information on different aspects of care.

Other Network Adequacy Issues

We support CMS’s proposal to require issuers to survey providers on a regular basis. In addition to asking whether providers are accepting new patients, issuers should also use this survey to assess whether providers still intend to be in-network and to verify other directory information, such as office location, contact information, and medical group and facility affiliations. **Issuers should also be required to contact providers that have not submitted claims within 6 or 12 months, to verify if they still intend to be in-network. Providers that don’t respond within a set time period should be removed from directories.**

Additionally, we support requiring issuers to make their criteria for selecting and tiering of providers available both to regulators and to the public. **We strongly urge CMS to require that the specific metrics or factors used to select and tier providers be made available for approval by regulators and to the public.** Although some issuers are using terms like “high value,” or “high performing” to describe their networks, there is very little information publicly

available about the criteria they use to select or tier providers. However, it often appears that inclusion of providers is being based largely on price, not on the quality of care provided. Moreover, issuers do not use uniform or standardized cost or quality criteria to select or tier providers, and this lack of consistency is confusing both to patients and to providers.

Part 158 – Issuer Use of Premium Revenue: Reporting and Rebate Requirements

§ 158.103 and § 158.140(a) Reporting of Incurred Claims

We do not recommend that CMS include fraud and abuse in the MLR calculations. We understand CMS’s desire to support prevention of fraud and abuse, and we agree that this is a priority for all Exchanges. Health insurance issuers should be aggressive about fraud and abuse; however, issuers should conduct such fraud and abuse prevention activities as part of their everyday operations.

Plans are supposed to select their providers carefully and they are expected to not engage in fraud and abuse. To the extent that any providers (or plans) have historically engaged in such activities, correcting it is a “cost of doing business” that should not detract from the value promised to plan enrollees. We do not believe such administrative expenses should be included in the numerator (or deducted from the denominator). We also note that it would be administratively challenging, if not impossible, to distinguish administrative activities related to fraud prevention (for example, a review of outlier claims for fraud review purposes) from other administrative activities. If this proposal is retained in the final rule, we recommend maintaining the cap of 0.5 percent of premium revenue. Expenses claimed here should show results over time or be disallowed.

Respectfully submitted,



Robert Restuccia
Executive Director
Community Catalyst